below the pylorus. As it was impracticable to reach the upper end, I seized the bar between my thumb and middle finger, and with the forefinger on the lower end of it, I retracted it upward and backward, for the purpose of making the incision in the stomach as high up as possible. I then passed a scalpel in, along the side of the forefinger, as a guide, and divided the coats of the stomach immediately at the end of the bar, making the incision parallel with the muscular fibres, and not larger than to admit of the removal of the lead. I then introduced a pair of long forceps, seized and drew out the lead. The external orifice was closed with the ordinary interrupted suture and adhesive strips; a compress was applied, and a roller around the body.

"The time of operating was twenty minutes; considerable delay was occasioned by the protrusion of the contents of the abdomen, which had to be replaced before the operation could proceed. As soon as the effects of the chloroform passed off, ¼ gr. sulph. morph. was administered, and the patient left in charge of a judicious medical attendant."

We need not give the details of the subsequent progress of the case; it is sufficient to say that convalescence was established as readily as after most of the minor surgical cases. "The patient was discharged on the 15th day after the operation, and has continued well up to this time; he is now residing in this village, working daily at his trade, that of a shoemaker. The orifice in the stomach was made on the left anterior side, and I think about one inch below the pylorus; the opening was just large enough to withdraw the lead. From some cause, probably from the efforts to vomit, a portion of the omentum had been forced out between the sutures, and when the adhesive strips were removed for the first time, it was found protruding from ½ to ¾ of an inch. Upon examination with a probe, I found it had formed adhesions on both sides of the orifice. I therefore removed the external portion with a pair of scissors.

"It may be a matter of surprise that an operation was not had sooner. Our reply to a question of that nature is, that an operation of that magnitude was not justifiable, as long as there was any doubt as to the lead being in the stomach; and the evening previous to the operation was the earliest time that all doubts of the fact had vanished, and the operation was performed at the earliest practicable moment thereafter. Although I had seen the patient occasionally for three or four days after this singular feat had been performed, and was called on the 8th to witness an operation, during all this time I had not seen one single symptom that was conclusive evidence of the presence of a bar of lead in the stomach.

"The length of the bar is 10⅛ inches, and its weight 9½ ounces avoirdupois."

Wound of the Stomach; Recovery.—Dr. C. Happoldt records (*Charleston Med. Journ. and Rev.*, May, 1855) an example of this:—

The subject of it was a lad 17 years of age, who, on the 10th February, received a wound from a bowie-knife, which entered at a spot three inches to the left of the middle of a line drawn from the ensiform cartilage to the umbilicus; and from the testimony of bystanders, the instrument penetrated to the depth of about four inches.

The patient had recently eaten large quantities of pastry and ground-nuts, and had drunk immediately before the accident a pint of sarsaparilla beer. Upon receiving the wound, he closed and wrestled with his opponent for some minutes, when he was taken away and conveyed in a carriage to his residence, where Dr. H. saw him at 5 P. M., one hour after the infliction of the injury.

"The longitudinal direction of the wound was parallel to the axis of the body, and was three-quarters of an inch in length; the edges were gaping widely; and there was no hemorrhage. The garments covering the thorax were saturated with a colourless, inodorous fluid, and the circumference of the wound was incrusted with about an ounce of white lardaceous matter. Having no probe at hand, I could not ascertain the depth or direction of the wound, but, from the fact of what appeared to have been the contents of the stomach having escaped through the external orifice, I concluded that the cavity of that viscus had been entered.

"Trusting that the wound of the stomach would close and adhere by the con-

traction and quiescence of the organ, I brought the edges of the tegumentary wound together by a single suture; and applied adhesive straps and a compress and bandage, to prevent muscular contraction and the access of air into the abdominal cavity. The patient was placed on his back: and the twelfth of a grain of the sulphate of morphine was given every two hours until he fell into a sound sleep."

Some fever supervened, which was subdued by appropriate remedies, and eleven days after the reception of the injury, the wound had closed.

"The case," Dr. H. remarks, "is rendered interesting from a favourable termination having occurred under the very circumstances which are universally regarded as most adverse and unfavourable to recovery. The stomach was full at the time when the perforation occurred, and, from the perturbation and compression to which it was necessarily subjected by the exertions of the patient, some of its contents were expelled not only externally through the parietal wound, but also into the abdominal cavity, as will be presently shown. Effusion of the contents of the stomach into the abdominal cavity constitutes the chief danger in these wounds. Percy, in the *Bulletin de la Faculté de Med.*, vol. i, p. 320 (quotes the writer of the article on wounds of the stomach in the *Dictionnaire de Médecine*) says that of twenty wounds of the stomach produced by the sword, the bayonet, or the knife, in which effusion into the abdominal cavity occurred, he has seen but four recover. All writers that have consulted on the subject attach the same importance to this accident. The portion of the gastric contents which escaped into the abdominal cavity must have been retained by the position of the contiguous organs in one spot, until adhesion of the peritoneal surfaces prevented its diffusion. Besides the inferences deducible from the circumstances related, I am strengthened in my opinion that some of the gastric contents did escape within the abdominal cavity by the nature of the matters which issued from the wound five days after the perforation occurred. Although I did not submit the discharge to a microscopic examination or chemical analysis, yet there were innumerable small particles which, from their feel, consistence, and odor, declared them to be the undigested particles of the ground-nuts which had been eaten a short time before the accident. The discharge was, moreover, whiter than pus or serum, and far more offensive. The gastric wound appeared to be near the pyloric orifice, and as the greater curve of the stomach must have been depressed at the time of the perforation, it is probable that the wound was nearer the upper wall or lesser curve of the organ. It might have been overstrained caution which led me to close the external wound as I did, and I cannot now see that any benefit resulted from it; but I could not, on first seeing the case, determine whether any of the gastric contents were lodged within the abdominal walls."

Luxation of the Head of the Radius backward, with Fracture of the Inner Condyle of the Humerus.—Dr. Thomas M. Markoe records (*New York Journ. of Med.*, May, 1855) the following cases of this infrequent accident:—

"*Case* I.—During the fall of 1849, I was sent for to see J. H., who had a day or two before fallen from a hay-loft, striking upon his left elbow. Great pain and inability to move the limb followed the accident, and soon after very great swelling round the injured joint, so that at the time of my seeing him it was impossible to trace the bony prominences of the articulation, and therefore an accurate diagnosis was out of the question. I was forced, therefore, to content myself with supporting the arm in a sling, with the elbow in a semi-flexed position, which was a comfortable one, and applying a cooling spirit-lotion to the inflamed joint with a view of reducing the swelling. This was sufficiently accomplished, at the end of a week's time, to enable me to ascertain that the head of the radius was dislocated backward, and projected behind the external condyle in such a manner that the finger could very plainly recognize the cup-like depression on its superior surface. At the same time, though there was some deformity about the internal portion of the joint, yet there was not sufficient projection backward of the olecranon for luxation of both bones, and the exact relation of the internal condyle and the olecranon could not be fully made out on account of the swelling, which seemed to be greater on this side than on